Wasatch County Hospital

Heber City, Utah

HOSPITAL UTILIZATION REVIEW PLAN

6-26-69

I. The Utilization Review Plan

A. The utilization review plan of Wasatch County Hospital is hereby established in accordance with the provisions of Public Law #89-97 involving care of Medicare patients and also in accordance with the recommendation of the Joint Commission. The plan itself has been developed with the advice of professional personnel including a physician and a registered nurse, and has been approved by the Board of Trustees of the Wasatch County Hospital for implementation on May 26, 1969.

B. The objectives of this plan are to maintain high-quality patient care and promote the most efficient use of available health services and facilities through the results of review procedures hereinafter outlined.

II. The Utilization Review Committee and its Functions

A. The Utilization Review Committee shall be composed of two members f of the Medical Staff selected by the Facility from the Medical Staff of the Hospital, and the administrator, the Director of Nursing Service and the Medical Records Technician. The number of appointments to the committee may vary from time to time as its activities require.

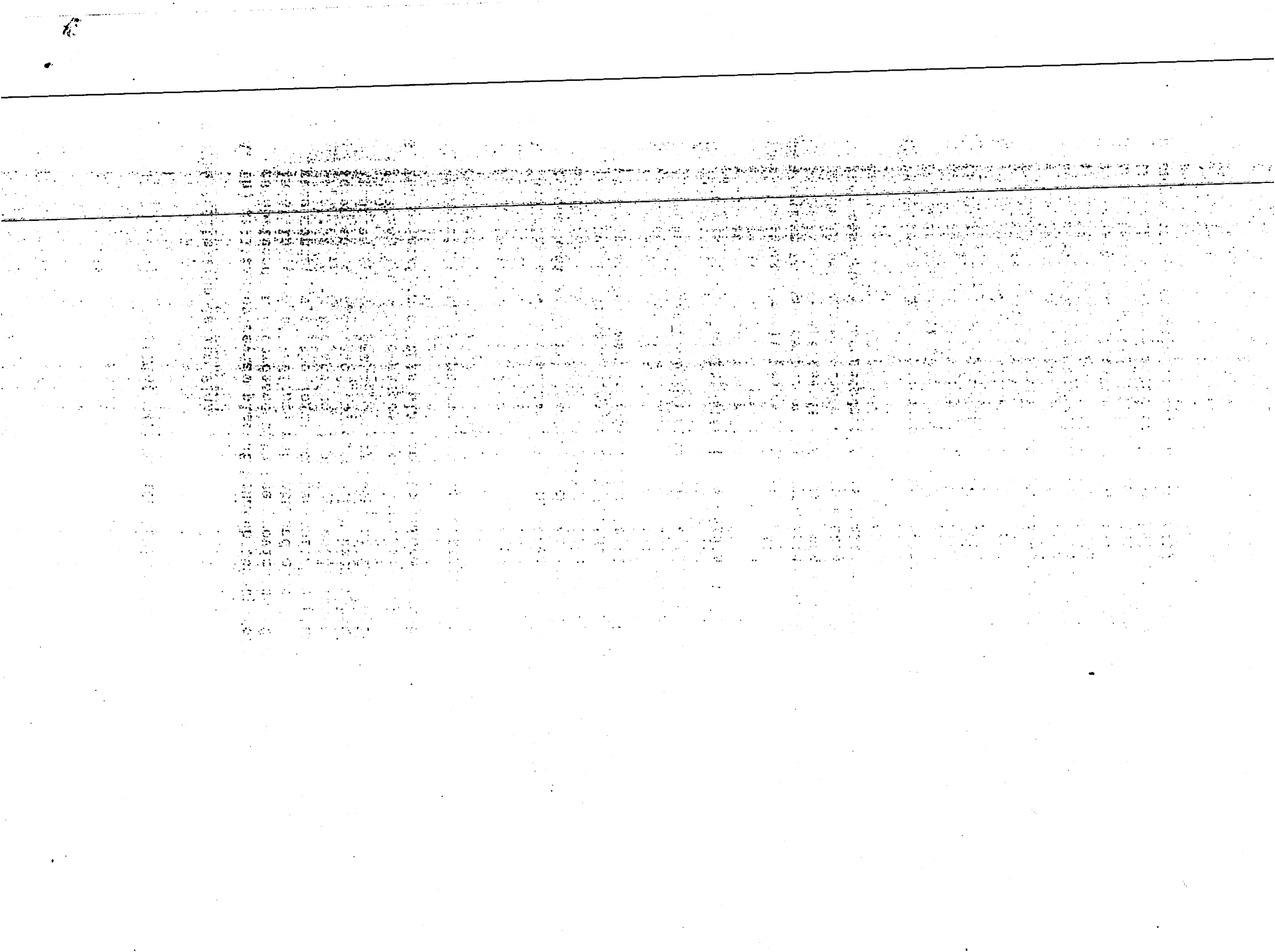
B. Committee members shall serve a two year term and will be able to succeed themselves as the need arises.

C. Meetings of the Committee shall be held at least monthly or more often as the occasion requires.

D. The Committee shall keep minutes of each meeting, recording at least a summary of the number and types of cases sampled and reviewed as well as the disposition of findings. These minutes shall be kept by the medical record technician. Committee action on each extended stay case shall be recorded; these shall be identified by case number only.

E. The Hospital Medical Records Department shall refer to the Committee any patient's chart whose stay is of an extended duration over or under the Hospital average stay as determined by the Utilization Review Committee and approved by the Staff.

F. Extended duration shall be understood to mean any case which is hospitalized seven days beyond the period determined in paragraph E, above. Government regulations require a first recertification no later than as of the fourteenth day of hospitalization and a second recertification no later than the 21st day of hospitalization and subsequent recertifications must be made at intervals which may be established from time to time, but in no event will the prescribed interval between recertifications exceed thirty days. Recertifications are to be made on the form provided.



G. All records on patients and any review of individual patient's stays shall be open to inspection by the fiscal intermediary.

III. Methods of Review

A. The Review function shall be carried out by two methods:
1. As approved in the previous section, which is the review of cases after discharge.

2. By a daily scanning of patients by a member of the Utilization Review Committee.

IV. Methods of Review (Specifics)

A. Each Medicare admission shall be tagged as such while the patient is in the hospital and subject to such review.

B. A tickler or reminder system shall be established by the office or record room for days on which review is required for each case.

C. The Committee will be notified each day of cases due for review within the subsequent seven days.

D. The committee shall develop a pattern for studying individual cases which are referred to them. This shall include consultation with the attending physician.

E. A record shall be made of the Committee's evaluation and determination as to medical necessity for hospitalization.

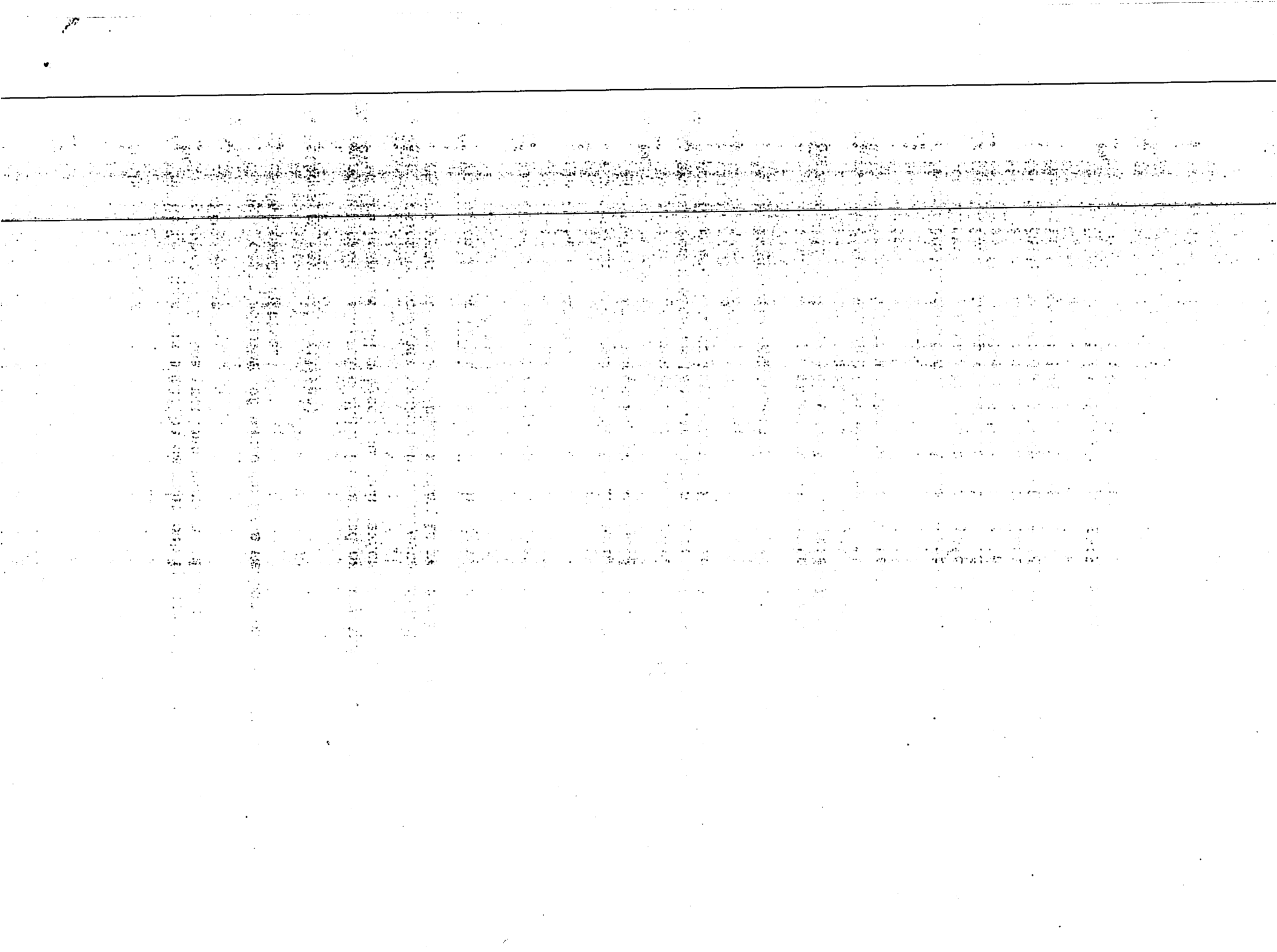
F. The patient, his physician and the hospital shall be notified when evaluation indicates that further stay is not medically necessary. Benefits cease three days after this notice is received by the hospital.

V. Review of Extended Duration Cases

A. A schedule of average stays for various categories of hospitalized cases will be developed as rapidly as possible and shall be revised from year to year. Until such a schedule is available, a case of extended duration shall be one where:
1. Length of continuous stay exceeds 21 days from the date of admission.

B. If the Utilization Review Committee decides after opportunity for consultation is given the attending physician, and considering the availability and appropriateness of out of hospital facilities and services, that further inpatient stay is not medically necessary, then the committee shall provide notification in writing, as previously outlined, within 48 hours of any decision which would terminate eligibility of Medicare benefits.

C. No physician shall have review responsibility for any case in which he was, or is, professionally involved.



VI. Relationship to Third Parties

A. The Utilization Review Committee shall cooperate with appropriate third parties, such as with the fiscal intermediary to assist in claims processing, which may include assisting in the evaluation of unusual cases. The committee also may use profiles or other statistical studies provided by a third party or sponsoring agency.

VII. Staff Cooperation

A. The Administration of the facility will study and promptly act on recommendations made by the utilization review committee.

B. The Committee shall leave the support and assistance of the facility's administration staff in abstracting information from medical charts, improving procedures, recording committee meetings, and providing current information on resources available for continued non-institutional or custodial care; the latter in order to insure continuity of care.

Date 6-26-69 Signed R. Raymond Green M.D.
Chairman, Utilization Review Committee

Date 6/26/69 Signed Fred W. Schlow
Administrator

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